WISCONSIN MEDICAID PROGRAM 2004 NURSING HOME COST REPORT

Completion of this form is required by Section 1.171 of the Methods of Implementation for Wisconsin Medicaid Nursing Home Payment Rates. Failure to complete and submit this form by the due date may result in a reduction or forfeiture of the payment rate, as provided in Section 49.45(13), Wis. Stats.

SCHEDULE 1 – FACILITY AND PREPARER INFORMATION AND CERTIFICATION

SECTION A – FACILITY INFORMATION

Facility Name	Contact Person	Contact Telephone Number	Main Telephone Number

Facility Street Address	City	State	Zip Code

Cost Report Period Start Date	Cost Report Period End Date	Medicaid Provider Number	Corporate Facility Number	POP ID Number

Administrator	Chief Financial Officer	Where are the financial records of the nursing home located?

SECTION B – PREPARER OF THE REPORT IF NOT AN EMPLOYEE OF THE PROVIDER

Name and Title	Telephone Number

Address	City	State	Zip Code

SIGNATURE – Original Signature of Preparer	Date Signed

SECTION C – CERTIFICATION BY AN OFFICER OR ADMINISTRATOR OF THE NURSING HOME

This certification must be signed and submitted before the information included in the cost report can be used to calculate Medicaid payment rates. Misrepresentation or falsification of any information contained in this report may be punishable by fine and/or imprisonment under state or federal law.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying report and any supporting schedules.

I HEREBY CERTIFY that to the best of my knowledge and belief, it is a true, correct, and complete report prepared from the books and records of the provider in accordance with applicable instructions, except as noted in the report.

SIGNATURE – Original Signature of Officer or Administrator of Nursing Home	Title	Date Signed

SECTION D – For Department Use	Date Received	Medicaid District Auditor

Medicaid Provider Number _____

SCHEDULE 2 - PROVIDER'S NOTES, COMMENTS AND QUALIFICATIONS REGARDING THE MEDICAID NURSING HOME COST REPORT

INSTRUCTIONS: This schedule may be used by the nursing home administrator, owners, officers and cost report preparers to provide notes, comments or qualifications regarding the financial and statistical data reported in the accompanying cost report. Attach additional sheets if necessary.

Commentator's Name	Title	Date

Medicaid Provider Number _____

SCHEDULE 3 – GENERAL INFORMATION

1. Type of Medicaid certification (check all that apply) ☐ (01) Nursing Facility ☐ (10) ICF-MR | For Department Use - Total

2. Type of license (check all that apply) ☐ (01) Skilled Nursing ☐ (20) Developmentally Disabled ☐ (10) Intermediate Care ☐ (40) IMD | For Department Use - Total

3. Type of ownership (check one) ☐ (1) Proprietary ☐ (2) Voluntary Non-Profit ☐ (3) Governmental

4. County of facility | For Department Use – County Code

5. Does the facility self-fund any of the fringe benefits reported on schedule 28? If yes, provide documentation to support the amount claimed. ☐ (1) Yes ☐ (2) No

6. Does the facility provide laundry services to residents for personal clothing? ☐ (1) Yes ☐ (2) No

7. Are any employes of the facility covered by a union contract? ☐ (1) Yes ☐ (2) No

8. Is the facility Medicare (Title XVIII) certified? ☐ (1) Yes ☐ (2) No

9. Fiscal Year Beginning Month | Fiscal Year Ending Month | For Department Use – End

10. List the number of licensed beds at the beginning of each month of the cost reporting period. Do not include restricted use beds.

BEDS	MONTH	BEDS	MONTH	BEDS	MONTH	For Department Use – Average Beds

If there has been any change in the number of licensed beds, briefly explain:

11. Has a certified audit been conducted for the cost reporting period? If yes, submit complete report copy including notes to the financial statements. ☐ (1) Yes ☐ (2) No

12. Check all related party transaction types for which expenses are reported. ☐ (1) Related party lease of building ☐ (2) Compensation to owners/ family relation ☐ (3) Interest expense on related party loans ☐ (4) Other related party transactions

13. Copies of the final adjusted trial balance for the cost reporting period, a reconciliation of the trial balance (reconciliation workpapers) and the asset depreciation schedules must be submitted. Have copies been made and included with this cost report? ☐ Yes ☐ No

14. Single occupancy rooms: On the right side of the license effective on the last day of the cost report period, you will find the capacity of 1 BED, 2 BED, 3 BED, and 4 BED rooms. Add the number of beds labeled 1 BED and enter it in column C (Single-Bed Rooms). Add the number of beds on all other lines and enter it in column D (Beds in Multiple-Bed Rooms). Add the number of beds in single rooms (column C) to the number of beds in multiple-bed rooms (column D) and enter the total in column E (Total Licensed Beds). This total must agree with the maximum capacity shown on your license. If your facility has more than one license, list each license on a separate line and total for each column.

A. Name	B. License Number	C. Single-Bed Rooms	D. Beds in Multiple-Bed Rooms	E. Total Licensed Beds
1.				
2.				
3.				
4. TOTAL				

Medicaid Provider Number _____

SCHEDULE 4 – MAJOR REVENUE GENERATING ACTIVITIES

Identify all major revenue generating activities with which the Medicaid nursing home provider is associated.	**Check services shared with the nursing home**							
	Nursing	**Sp. Care**	**Dietary**	**Maint.**	**Hskg.**	**Laundry**	**A & G**	**Util.**
1. Another Medicaid NH provider, Name of provider:	☐	☐	☐	☐	☐	☐	☐	☐
2. Hospital, Name of hospital: Beds at end of cost report period:	☐	☐	☐	☐	☐	☐	☐	☐
3. Non-Medicaid NH unit or structure, Beds at end of cost report period:	☐	☐	☐	☐	☐	☐	☐	☐
4. Non-Medicaid CBRF, Beds at end of cost report period:	☐	☐	☐	☐	☐	☐	☐	☐
5. Room and board unit or structure, Beds at end of cost report period:	☐	☐	☐	☐	☐	☐	☐	☐
6. Apartment units, Units at end of cost report period:	☐	☐	☐	☐	☐	☐	☐	☐
7. School, Describe: Does school serve students under 21? ☐ Yes ☐ No	☐	☐	☐	☐	☐	☐	☐	☐
8. Outpatient mental health clinic	☐	☐	☐	☐	☐	☐	☐	☐
9. Contract with county mental health/disability board for special services to NH patients, Describe:	☐	☐	☐	☐	☐	☐	☐	☐
10. Therapy services, Describe:	☐	☐	☐	☐	☐	☐	☐	☐
11. Pharmacy	☐	☐	☐	☐	☐	☐	☐	☐
12. Laboratory or radiology services	☐	☐	☐	☐	☐	☐	☐	☐
13. Rental of building space	☐	☐	☐	☐	☐	☐	☐	☐
14. Elderly or other day care	☐	☐	☐	☐	☐	☐	☐	☐
15. Elderly home care	☐	☐	☐	☐	☐	☐	☐	☐
16. Fund raising activities	☐	☐	☐	☐	☐	☐	☐	☐
17. Farm	☐	☐	☐	☐	☐	☐	☐	☐
18. Food catering services (meals on wheels, etc.)	☐	☐	☐	☐	☐	☐	☐	☐
19. Child care	☐	☐	☐	☐	☐	☐	☐	☐
20. Clinic	☐	☐	☐	☐	☐	☐	☐	☐
21. Other, Describe:	☐	☐	☐	☐	☐	☐	☐	☐

Medicaid Provider Number _____

SCHEDULE 5 – BUILDING SQUARE FOOTAGE

SECTION A – GENERAL INFORMATION	**Wing A**	**Wing B**	**Wing C**	**Wing D**
Name or description of building or wing				
Year construction was functionally completed on building or wing				
Total Square footage of building or wing				
SECTION B – NURSING HOME SERVICE AREAS				
1. Nuns or other employes' housing	sq.ft.	sq.ft.	sq.ft.	sq.ft.
2. Employes' unique fringe benefit areas				
3. Dietary (kitchen, food preparation & storage, dish washing, kitchen cleanup)				
4. Plant equipment (furnace/boiler room, electrical, water, similar plant equip.)				
5. Laundry (washing/drying rooms, sorting/folding rooms, central linen storage)				
6. Administration (general/accounting offices, reception areas, meeting rooms)				
7. Laboratory and radiology				
8. Pharmacy				
9. Physical therapy				
10. Occupational therapy				
11. Other therapies				
12. Beauty and barber shops				
13. Gift shop, canteen, snack shop				
14. Patient areas (rooms, bathrooms, halls, nurse desk/office, dayrooms, rec.)				
SECTION C – RENTED AND OTHER MAJOR REVENUE ACTIVITY AREAS (SEE SCHEDULE 4). IDENTIFY EACH ACTIVITY.				
15. Hospital direct patient service areas				
16. _____				
17. _____				
18. _____				
SECTION D –OTHER AREAS				
19. Major idle or closed areas				
20. Residual unidentified square footage (Total area less lines 1 through 19)				

Describe general purpose or use of line 20 square footage:

FOR DEPT. USE – NET SQ. FT.

Medicaid Provider Number _____

SCHEDULE 6 – TOTAL PATIENT DAYS

SECTION A – INHOUSE PATIENT DAYS

	LEVEL OF CARE									
	DD 3	DD 2	DD 1B	DD 1A	ICF 3&4	ICF 2	ICF 1	SNF	ISN	TOTAL
1. Medicaid (T-19)										
2. Medicare (T-18)										
3. Private pay										
4a. Family Care Medicaid (T-19)										
4b. Family Care all other										
5. Other, Specify:										
6. TOTAL INHOUSE PT. DAYS										

SECTION B – BEDHOLD DAYS

	LEVEL OF CARE									
	DD 3	DD 2	DD 1B	DD 1A	ICF 3&4	ICF 2	ICF 1	SNF	ISN	TOTAL
7. Medicaid (T-19)										
8. All Other										
9. TOTAL BEDHOLD DAYS . . .										

SECTION C – TOTAL PATIENT DAYS

	LEVEL OF CARE									
	DD 3	DD 2	DD 1B	DD 1A	ICF 3&4	ICF 2	ICF 1	SNF	ISN	TOTAL
10. TOTAL DAYS (lines 6 + 9)										

11. Is your facility a distinct part ICF-MR (certified as both a NF and ICF-MR)? If yes, complete schedule 7 . . . . . ☐ Yes ☐ No

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SCHEDULE 7 – PATIENT DAYS IN DISTINCT PART ICF-MR FACILITIES

INSTRUCTIONS: This schedule is to be completed only for facilities with a distinct part ICF-MR (certified as both a NF and ICF-MR). Report only patient days for the ICF-MR distinct part of the facility. These patient days should also be included on schedule 6.

	DD 3	DD 2	DD 1B	DD 1A	ICF 3&4	ICF 2	ICF 1	SNF	ISN	TOTAL
1. Inhouse patient days										
2. Bedhold days										
3. TOTAL DAYS										

SCHEDULE 8 – TOTAL PATIENT DAYS BY MONTH

MONTH													TOTAL
1. Inhouse pt. days													
2. Bedhold days . . .													
3. TOTAL DAYS . .													

SCHEDULE 9A – HOSPICE PATIENT DAYS

	DD 3	DD 2	DD 1B	DD 1A	ICF 3&4	ICF 2	ICF 1	SNF	ISN	TOTAL
1. Inhouse patient days										
2. Bedhold days										
3. TOTAL DAYS										

SCHEDULE 9B – VENTILATOR DEPENDENT PATIENT DAYS

	DD 3	DD 2	DD 1B	DD 1A	ICF 3&4	ICF 2	ICF 1	SNF	ISN	TOTAL
1. Inhouse Patient Days										
2. Bedhold Days										
3. TOTAL DAYS										

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SCHEDULE 10 – BALANCE SHEET

ASSETS		Begin Date	End Date
CURRENT ASSETS	Cash on hand and in bank	$	$
	Temporary investments		
	Resident accounts receivable		
	Other accounts receivable		
	Due from related parties		
	Notes receivable		
	Accrued interest receivable		
	Inventories		
	Prepaid expenses		
	Resident funds held in trust		
	Other current assets, list below:		
	TOTAL CURRENT ASSETS	$	$
PROPERTY, PLANT, EQUIP.	Land	$	$
	Land improvements		
	Buildings		
	Leasehold improvements		
	Fixed equipment		
	Moveable equipment		
	Transportation equipment		
	Other		
	Less: accumulated depreciation	( )	( )
	TOTAL PROPERTY, PLANT, EQUIPMENT	$	$
OTHER	Long term investments	$	$
	Other Assets, list below:		
	TOTAL OTHER ASSETS	$	$
TOTAL ASSETS		$	$

LIABILITIES AND OWNERS' EQUITY		Begin Date	End Date
CURRENT LIABILITIES	Notes and loans payable, list below:		
		$	$
	Due to related parties		
	Accounts payable		
	Accrued salaries		
	Other accrued expenses		
	Resident trust funds payable		
	Other current liabilities		
	TOTAL CURRENT LIABILITIES	$	$
LONG TERM LIAB.	Notes and loans payable, list below:		
		$	$
	Other long term liabilities		
	TOTAL LONG TERM LIABILITIES	$	$
OWNER EQUITY	**OWNERS' EQUITY, list below:**		
		$	$
	TOTAL OWNER'S EQUITY	$	$
TOTAL LIABILITIES AND EQUITY		$	$

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SCHEDULE 10A – SUMMARY OF CHANGES IN OWNERS' EQUITY

1. Beginning Owners' Equity (from schedule 10)			$ _____
2. Add	Net income (from schedule 11, line 21)	$ _____	
	Owners' capital contribution	_____	
	County appropriation	_____	
	Other, Specify: _____	_____	
	Other, Specify: _____	_____	
	Total additions		_____
3. Deduct	Net loss (from schedule 11, line 21)	$ (_____)	
	Dividends and withdrawals	(_____)	
	Other, Specify: _____	(_____)	
	Other, Specify: _____	(_____)	
	Total deductions		(_____)
4. ENDING OWNERS' EQUITY (schedule 10)			$ _____

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SCHEDULE 11 – SUMMARY OF REVENUES AND EXPENSES

SECTION A – SUMMARY OF REVENUE

1. Daily patient service revenue	schedule 14, line 12	$
2. Service fees	schedule 15, line 14A	
3. Rent from outside medical providers	schedule 15, line 14B	
4. Other	schedule 15, line 14C	
5. Dietary revenues	schedule 16, line 5A	
6. Miscellaneous services and materials revenue	schedule 16, line 17	
7. Rental revenues	schedule 17, line 21A	
8. Revenues from other major activities	schedule 17, line 37	
9. Sales to related organizations	schedule 18, line 41	
10. Investment revenue	schedule 18, line 45	
11. Gains (Losses) on disposal of assets	schedule 18, line 53	
12. Grants for government-subsidized employes	schedule 18, line 57	
13. Grants, contributions, donations	schedule 18, line 62	
14. Other revenue	schedule 18, line 69	
15. Subtract: deductions from revenues	schedule 19, line 9	( )
16. NET REVENUES		$

SECTION B – SUMMARY OF NET INCOME OR LOSS

17. Subtract: total expenses	schedule 12, line 39	$ ( )
18. Add or subtract the amount to adjust related party transactions to cost	schedule 42, line 15	
19. NET INCOME OR LOSS BEFORE INCOME TAXES		$
20. Subtract income taxes – optional	schedule 38, line 6	( )
21. NET INCOME OR LOSS AFTER INCOME TAXES		$

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SCHEDULE 12 – SUMMARY OF TOTAL EXPENSES

Cost Center	Reference	Expense
1. Daily patient service expense	S20, L16	$
2. Laboratory	S21, L15	
3. Radiology	S21, L15	
4. Pharmacy	S21, L15	
5. Physical Therapy	S22, L15	
6. Occupational Therapy	S22, L15	
7. Physician	S22, L15	
8. Social Services	S23, L15	
9. Recreational Activities	S23, L15	
10. Religious Services	S23, L15	
11. Speech	S24, L15	
12. Dental	S24, L15	
13. Psychotherapy	S24, L15	
14. Respiratory Care	S24, L15	
15. Volunteer coordinator, ward clerks, other	S24A, L15	
16. Dietary	S25, L19	
17. Plant operation and maintenance	S25, L19	
18. Housekeeping	S25, L19	
19. Laundry and linen	S25, L19	
20. Security	S25, L19	
21. Transportation	S25, L19	
22. Administrative service expense	S26, L12	
Other cost centers, Specify:		
23. _____	S27, L18	
24. _____	S27, L18	
25. _____	S27, L18	
26. _____	S27, L18	
27. _____	S27, L18	
UNASSIGNED EXPENSES		
28. Employee fringe benefit expense	S28, L17	
29. Heating fuel and utility expense	S29, L10	
30. Interest on operating working capital loans	S30. L6	
31. Insurance expense	S31, L9	
32. Amortization expense	S32, L5	
33. Interest on plant asset loans	S33, L8	
34. Depreciation expense	S34, L20	
35. Expense on operating and non-cap.leases	S35, L9	
36. Expense on capitalized leases	S36, L3	
37. Property tax expense	S37, L8	
38. Other non-salary expense	S39, L4	
39. TOTAL EXPENSES FOR REPORT PERIOD (Sum 1-38) (To schedule 11, line 17)		$

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SCHEDULE 13 – SUMMARY OF SALARY AND WAGE EXPENSES

Cost Center and Schedule		A. Expense for Productive Hrs (line 1)	B. Expense for Non-Prod. Hrs (line 3)	C. Total Salary, Wage Exp. (line 5)
Daily patient service	20	$	$	$
Laboratory	21			
Radiology	21			
Pharmacy	21			
Physical therapy	22			
Occupational therapy	22			
Physician	22			
Social services	23			
Recreational activities	23			
Religious services	23			
Speech	24			
Dental	24			
Psychotherapy	24			
Respiratory care	24			
Volunteer coordinator	24A			
Ward clerks	24A			
Other	24A			
Dietary	25			
Plant operation / maint.	25			
Housekeeping	25			
Laundry and linen	25			
Security	25			
Transportation	25			
Administrative service	26			
Nurse aide training	27			
Beauty and barber	27			
Other, Specify:	27			
_____				
_____				
_____				
TOTAL SALARY AND WAGE EXP		$	$	$

For Department Use	Productive	Non-Productive	TOTAL

Medicaid Provider Number _____

SCHEDULE 14 – DAILY PATIENT SERVICE REVENUES

INSTRUCTIONS: If a facility has received its retroactive Medicaid rate adjustment, the adjusted revenues should be included in line 2 for the months of service in the cost reporting period. Some facilities may have not received the retroactive Medicaid rate adjustments due to them for services provided during the months of the cost reporting period.

SECTION A – DAILY RATE CHARGES	**Revenue**
1. Medicare	$
2. Medicaid	
3. Private Pay	
4. Other	
SECTION B – BED HOLD CHARGES	
5. Medicaid	
6. Private Pay	
7. Other	
SECTION C – MEDICAL SUPPLIES	
8. Inpatient	
9. Outpatient	
10. Other, Specify: _____	
11. OTC drugs	
SECTION D – TOTAL	
12. TOTAL DAILY PATIENT SERVICE REVENUE	$

Do Medicaid revenues on Line 2 include retroactive Medicaid rate adjustments? (Check one)

- ☐ Yes, all significant retroactive Medicaid rate adjustments are included.
- ☐ No, substantial retroactive Medicaid rate adjustments are NOT included.
- ☐ Estimate, an estimate of retroactive Medicaid rate adjustments IS included
- ☐ Other, Specify _____

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SCHEDULE 15 – SPECIAL SERVICE REVENUES

INSTRUCTIONS: Refer to schedules 25A, 25B, 26B, 29, and 40 and their instructions regarding the allocation of general services and property expenses to those building areas which are used for providing the revenue generating services or which are rented out for those services. If applicable, administrative service expenses must be allocated to the revenue generating service.

For Column B (Rent Revenue), describe the rental fee basis (example: rent per month, percent of charges) and the services, equipment, and square feet of space furnished to the outside provider. Add additional sheets if necessary.

SECTION A – SERVICE REVENUES	A. Service Fee Charges	B. Rent from Outside Medical Providers	C. From Other Sources	Describe Other
1. Laboratory	$	$	$	
2. Radiology				
3. Pharmacy				
4. Physical therapy				
5. Speech/hearing therapy				
6. Occupational therapy				
7. Physician care				
8. Psychotherapy				
9. Respiratory therapy				
10. Social services				
11. Recreational activities				
12. Special duty nursing				
13. Other, Specify: _____				
14. TOTAL SPECIAL SERVICE REVENUE	$	$	$	

If totals exceed $4,000, see instructions above.

SECTION B – THERAPY REVENUES

15. Are physical, occupational, or speech therapy services provided by staff, assistants, contractors, or consultants IN SPACE AT YOUR FACILITY? ☐ Yes ☐ No

16. Total gross revenues for physical, occupational, and speech therapy services provided at your facility during the cost report period . . . . . $ _____

Provide the total regardless of who provides the services, who bills for the services, or who receives the services (residents vs. non-residents).

17. From section A, total the amounts in columns A, B and C on lines 4, 5 and 6 (sum 4A , 4B, 4C, 5A, 5B, 5C, 6A, 6B, 6C) . . . . . $ _____

18. If there is any variance between the totals reported on lines 16 and 17, explain. _____

19. Are therapy services provided to individuals in addition to your nursing home residents? ☐ Yes ☐ No **If yes, amount of revenue** **$** _____

20. Does your facility or related organization bill Medicare Part B for therapy services at your facility? ☐ Yes ☐ No **If yes, amount of revenue** $ _____

21. Did you charge rent to a rehabilitation agency or independent contractor? ☐ Yes ☐ No **If yes, amount of revenue** $ _____

Medicaid Provider Number _____

SCHEDULE 16 – OTHER REVENUES

SECTION A – CAFETERIA AND DIETARY REVENUE

1. Donated and surplus food commodities	$	Included in food supply expense for donated/surplus	
2. Dietary supplies sold		Cost of dietary supplies sold (if known)	
3. Meals sold to employees (transfer to sched. 25A, line 10)			
4. Meals on wheels			
5. Other meals sold			
5a. TOTAL DIETARY REVENUE	$		

SECTION B – MISCELLANEOUS SERVICES AND MATERIALS

	Revenue	Expenses Directly Ascribable To Or Identifiable With Revenue			
		A. Related Direct Expense (if known)	B. Cost Center where expense included	C. Schedule Number	D. Line Number
6a. Personal laundry services for private pay residents	$	$			
6b. Other laundry serv., Specify: _____		$			
7. Dry cleaning services		$			
8. Sale of personal hygiene items		$			
9. Transportation		$			
10. Beauty and barber shops		$			
11. Gift shop		$			
12. Canteen and snack counter		$			
13. Vending machines		$			
14. Sale of clothing		$			
15. Television and radio		$			
16. Telephone and telegraph		$			
17. TOTAL MISCELLANEOUS SERVICES AND MATERIALS	$				

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SCHEDULE 17 – OTHER REVENUES

INSTRUCTIONS: For Section C, refer to schedules 25A, 25B, 29, and 40 and their instructions regarding the allocation of expenses to rented equipment or building space.

For section D, only report revenues if the direct expenses and the shared and indirect expenses associated with the revenue activity are reported in this cost report. See schedule 4 or Section 700 of the instructions for more details on the reporting of expenses.

SECTION C – RENTAL REVENUE	Revenue	Property Rented	Square Feet Rented	Services Provided
18. Equipment rental	$			
19. Rental of nursing home space				
20. Rental of non-nursing home space				
21. Parking				
21a.TOTAL RENTAL REVENUES	$			

SECTION D – REVENUE FROM MAJOR ACTIVITIES	Revenue	Total Billable Patient Days if revenue generated from activities 24,25,26
22. Another Medicaid nursing home provider	$	
23. Hospital		
24. A non-Medicaid nursing home unit		
25. A non-Medicaid residential facility (CBRF)		
26. Room and board unit or structure		
27. Apartment units		
28. Child care institution		
29. School		
30. Outpatient mental health clinic		
31. Elderly or other day care		
32. Elderly home care		
33. Farm		
34. _____		
35. _____		
36. _____		
37. TOTAL REVENUE FROM OTHER MAJOR ACTIVITIES	$	

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SCHEDULE 18 – OTHER REVENUES

SECTION E – SALES TO RELATED ORGANIZATIONS	Revenue
38.	$
39.	
40.	
41. TOTAL SALES TO RELATED ORGANIZATIONS	$

SECTION F – INTEREST AND INVESTMENT REVENUE	Revenue
42. Revenue from invested gift/grant funds not commingled with other funds	$
43. Revenue from invested funds used for current cash needs	
44. Other revenue from invested funds	
45. TOTAL INVESTMENT REVENUE	$

46. If total investment revenue exceeds $6,000, describe major investments (type, invested amount, purpose if any)

_____

_____

_____

SECTION G – GAINS (LOSSES) DISPOSAL OF ASSETS	Gain (Loss)
47. Land	$
48. Land improvements, buildings, fixed equipment	
49. Moveable equipment	
50. Transportation vehicles	
51. Investment securities	
52. Other assets, Specify: _____	
53. TOTAL GAINS (LOSSES) ON DISPOSAL OF ASSETS . . .	$

SECTION H – GRANTS FOR GOVT. SUBSIDIZED EMP.	Revenue
54.	$
55.	
56.	
57. TOTAL GRANTS FOR GOVT. SUBS. EMPLOYES . .	$

SECTION I – GRANTS, CONTRIBUTIONS, DONATIONS	Revenue
58. Donated services (see 64 below)	$
59. Donated supplies and materials (see 64 below)	
60. General donations and contributions	
61. Donor restricted funds used for current operations (see 64 below)	
62. TOTAL GRANTS, CONTRIBUTIONS, DONATIONS . .	$
63. Donor restricted funds for plant asset purchase or debt retirement (do not transfer to schedule 11)	$

64. For lines 58, 59 and 61, attach a sheet describing the items, amount of related expense reported in this cost report, and where the expense is reported.

SECTION J – OTHER REVENUES	Revenue
65.	$
66.	
67.	
68.	
69. TOTAL OTHER REVENUES	$

Medicaid Provider Number _____

SCHEDULE 19 – DEDUCTIONS FROM REVENUES

INSTRUCTIONS: This schedule outlines deductions from revenue for amounts reported on schedules 14 and 15. Deductions from revenue are amounts which should be subtracted from revenues to determine net realized revenues. Such deductions are not expenses.

SECTION A – MISCELLANEOUS		**Revenue Deductions**
1. Bad debts		$
2. Charity Service		
SECTION B – DAILY SERVICE AND SPECIAL SERVICE CONTRACTUAL ADJUSTMENTS		
3. Medicare	Physical therapy	$
	Speech therapy	
	Occupational therapy	
	All other	
4. Medicaid	Physical therapy	
	Speech therapy	
	Occupational therapy	
	All other	
5. Other	Physical therapy	
	Speech therapy	
	Occupational therapy	
	All other	
SECTION C – OTHER DEDUCTIONS FROM REVENUE		
6. _____		$
7. _____		
8. _____		
SECTION D – TOTAL		
9. TOTAL DEDUCTIONS FROM REVENUE (Sum 1-9)		$

Medicaid Provider Number _____

SCHEDULE 20 – DAILY PATIENT SERVICE EXPENSES

SALARIES, WAGES, PURCHASED SERV.	A. Registered Nurses	B. Licensed Practical Nurses	C. Nurse Aides and Assistants	D. Resident Living Staff	E. Total Expense/Hrs. (sum A – D)
1. Expense for productive hours worked	$	$	$	$	$
2. Number of productive hours worked	hrs.	hrs.	hrs.	hrs.	hrs.
3. Expense for non-productive hours	$	$	$	$	$
4. Number of non-productive hours	hrs.	hrs.	hrs.	hrs.	hrs.
5. TOTAL SALARY AND WAGE EXPENSE	$	$	$	$	$
5a. TOTAL SALARY AND WAGE HOURS (line E2 + E4)					hrs.
6. Expense for purchased services	$	$	$	$	$
7. This line no longer used					

INCONTINENCY SUPPLIES

8. Purchased laundry service for diapers/underpads, Specify vendor: _____ $ _____

9. Diapers, underpads, and other paper and cloth incontinency supplies . . . . . _____

10. Catheter and bladder irrigation supplies and other incontinency apparatuses . . . . . _____

OXYGEN

11. Oxygen, or daily rental of oxygen concentrators, all other oxygen supplies and cylinder rental . . . . . _____

OTHER

12. Other medical supplies, personal comfort supplies, and minor medical equipment . . . . . _____

13. Nonbillable over the counter (OTC) drugs for all residents (include other OTC drugs billable on drug claim forms schedule 21, line 11) . . . . . _____

13a. The OTC drug allowance will be based only on the cost of OTC drugs for Medicaid residents. Of the total OTC expenses reported on line 13, indicate ONLY the expense for OTC drugs provided to Medicaid residents . . . . . _____

14. _____ _____

15. _____ _____

16. TOTAL DAILY PATIENT SERVICE EXPENSE (Sum 5, 6, 8-13, 14, 15) . . . . . $ _____

Medicaid Provider Number _____

SCHEDULE 21 – SPECIAL SERVICE EXPENSES

	TYPE OF SERVICE		
SECTION A – SALARY AND WAGES	**A. Laboratory**	**B. Radiology**	**C. Pharmacy**
1A. Expense for productive hours worked – Billable	$	$	$
2A. Number of productive hours worked – Billable	hrs,	hrs.	hrs.
1B. Expense for productive hours worked – Non billable	$ -0-	$ -0-	$
2B. Number of productive hours worked – Non billable	-0- hrs.	-0- hrs.	hrs.
3. Expense for non-productive hours	$	$	$
4. Number of non-productive hours	hrs.	hrs.	hrs.
5. TOTAL SALARY AND WAGE EXPENSE	$	$	$
SECTION B – PURCHASED SERVICES			
6. Expense for purchased service – Billable	$	$	$
7. Number of hours of purchased service – Billable (optional)	hrs.	hrs.	hrs.
8. Expense for purchased service – Non billable	$ -0-	$ -0-	$
9. Number of hours of purchased service – Non billable	-0- hrs.	-0- hrs.	hrs.
SECTION C – SUPPLY AND OTHER EXPENSE			
10. Pharmacy – legend drugs Billable	$ -0-	$ -0-	$
11. Pharmacy – over the counter drugs Billable	-0-	-0-	
12. Supply and Other			
13. _____			
14. _____			
SECTION D - TOTAL			
15. TOTAL EXPENSES (Sum 5,6,8,10-14)	$	$	$
16. TOTAL HOURS (Sum 2a,2b,4,7,9)	hrs.	hrs.	hrs.

Medicaid Provider Number _____

SCHEDULE 22 – SPECIAL SERVICE EXPENSES

	TYPE OF SERVICE		
SECTION A – SALARY AND WAGES	**A. Physical Therapy**	**B. Occupational Therapy**	**C. Physician**
1A. Expense for productive hours worked – Billable	$	$	$
2A. Number of productive hours worked – Billable	hrs.	hrs.	hrs.
1B. Expense for productive hours worked – Non billable	$	$	$
2B. Number of productive hours worked – Non billable	hrs.	hrs.	hrs.
3. Expense for non-productive hours	$	$	$
4. Number of non-productive hours	hrs.	hrs.	hrs.
5. TOTAL SALARY AND WAGE EXPENSE	$	$	$
SECTION B – PURCHASED SERVICES			
6. Expense for purchased service – Billable	$	$	$
7. Number of hours of purchased service – Billable (optional)	hrs.	hrs.	hrs.
8. Expense for purchased service – Non billable	$	$	$
9. Number of hours of purchased service – Non billable	hrs.	hrs.	hrs.
SECTION C – SUPPLY AND OTHER EXPENSE			
10. _____	$	$	$
11. _____			
12. _____			
13. _____			
14. _____			
SECTION D - TOTAL			
15. TOTAL EXPENSES (Sum 5,6,8,10-14)	$	$	$
16. TOTAL HOURS (Sum 2a,2b,4,7,9)	hrs.	hrs.	hrs.

Medicaid Provider Number _____

SCHEDULE 23 – SPECIAL SERVICE EXPENSES

	TYPE OF SERVICE		
SECTION A – SALARY AND WAGES	**A. Social Services**	**B. Recreational Activities**	**C. Religious Services**
1A. Expense for productive hours worked – Billable	$ -0-	$ -0-	$ -0-
2A. Number of productive hours worked – Billable	-0- hrs.	-0- hrs.	-0- hrs.
1B. Expense for productive hours worked – Non billable	$	$	$
2B. Number of productive hours worked – Non billable	hrs.	hrs.	hrs.
3. Expense for non-productive hours	$	$	$
4. Number of non-productive hours	hrs.	hrs.	hrs.
5. TOTAL SALARY AND WAGE EXPENSE	$	$	$
SECTION B – PURCHASED SERVICES			
6. Expense for purchased service – Billable	$ -0-	$ -0-	$ -0-
7. Number of hours of purchased service – Billable (optional)	-0- hrs.	-0- hrs.	-0- hrs.
8. Expense for purchased service – Non billable	$	$	$
9. Number of hours of purchased service – Non billable	hrs.	hrs.	hrs.
SECTION C – SUPPLY AND OTHER EXPENSE			
10. _____	$	$	$
11. _____			
12. _____			
13. _____			
14. _____			
SECTION D - TOTAL			
15. TOTAL EXPENSES (Sum 5,6,8,10-14)	$	$	$
16. TOTAL HOURS (Sum 2a,2b,4,7,9)	hrs.	hrs.	hrs.

Medicaid Provider Number _____

SCHEDULE 24 – OTHER TYPES OF SPECIAL SERVICE EXPENSES

	TYPE OF SERVICE			
SECTION A – SALARY AND WAGES	**A. Speech**	**B. Dental**	**C. Psychotherapy**	**D. Respiratory Care**
1A. Expense for productive hours worked – Billable	$	$	$	$
2A. Number of productive hours worked – Billable	hrs.	hrs.	hrs.	hrs.
1B. Expense for productive hours worked – Non billable	$	$	$	$
2B. Number of productive hours worked – Non billable	hrs.	hrs.	hrs.	hrs.
3. Expense for non-productive hours	$	$	$	$
4. Number of non-productive hours	hrs.	hrs.	hrs.	hrs.
5. TOTAL SALARY AND WAGE EXPENSE	$	$	$	$
SECTION B – PURCHASED SERVICE				
6. Expense for purchased service – Billable	$	$	$	$
7. Number of hours of purchased service – Billable (optional)	hrs.	hrs.	hrs.	hrs.
8. Expense for purchased service – Non billable	$	$	$	$
9. Number of hours of purchased service – Non billable	hrs.	hrs.	hrs.	hrs.
SECTION C – SUPPLY AND OTHER EXPENSE				
10. _____	$	$	$	$
11. _____				
12. _____				
13. _____				
14. _____				
SECTION D - TOTAL				
15. TOTAL EXPENSES (Sum 5,6,8,10-14)	$	$	$	$
16. TOTAL HOURS (Sum 2a,2b,4,7,9)	hrs.	hrs.	hrs.	hrs.

Medicaid Provider Number _____

SCHEDULE 24A – OTHER TYPES OF SPECIAL SERVICE EXPENSES

	TYPE OF SERVICE			
SECTION A – SALARY AND WAGES	**A. Volunteer Coord.**	**B. Ward Clerks**	**C.**	**D.**
1A. Expense for productive hours worked – Billable	$ -0-	$ -0-	$	$
2A. Number of productive hours worked – Billable	-0- hrs.	-0- hrs.	hrs.	hrs.
1B. Expense for productive hours worked – Non billable	$	$	$	$
2B. Number of productive hours worked – Non billable	hrs.	hrs.	hrs.	hrs.
3. Expense for non-productive hours	$	$	$	$
4. Number of non-productive hours	hrs.	hrs.	hrs.	hrs.
5. TOTAL SALARY AND WAGE EXPENSE	$	$	$	$
SECTION B – PURCHASED SERVICE				
6. Expense for purchased service – Billable	$ -0-	$ -0-	$	$
7. Number of hours of purchased service – Billable (optional)	-0- hrs.	-0- hrs.	hrs.	hrs.
8. Expense for purchased service – Non billable	$	$	$	$
9. Number of hours of purchased service – Non billable	hrs.	hrs.	hrs.	hrs.
SECTION C – SUPPLY AND OTHER EXPENSE				
10. _____	$	$	$	$
11. _____				
12. _____				
13. _____				
14. _____				
SECTION D - TOTAL				
15. TOTAL EXPENSES (Sum 5,6,8,10-14)	$	$	$	$
16. TOTAL HOURS (Sum 2a,2b,4,7,9)	hrs.	hrs.	hrs.	hrs.

Medicaid Provider Number _____

SCHEDULE 25 – GENERAL SERVICE EXPENSES

SECTION A – SALARIES AND WAGES	**A. Dietary**	**B.Plant Op./Maint.**	**C. Housekeeping**	**D. Laundry / Linen**	**E. Security**	**F. Transportation**
1. Expense for productive hours worked	$	$	$	$	$	$
2. Number of productive hours worked	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
3. Expense for non-productive hours	$	$	$	$	$	$
4. Number of non-productive hours	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
5. TOTAL SALARY AND WAGE EXPENSE	$	$	$	$	$	$
SECTION B – DIETICIAN CONSULTANT						
6. Dietician consultant expense	$	$	$	$	$	$
7. This line no longer used						
SECTION C – OUTSIDE SERVICE						
8. _____	$	$	$	$	$	$
9. _____						
10. _____						
11. _____						
SECTION D – FOR DEPARTMENT USE						
12. _____	$	$	$	$	$	$
SECTION E – SUPPLY AND OTHER EXPENSE						
13. _____	$	$	$	$	$	$
14. _____						
15. _____						
16. _____						
17. _____						
SECTION F – FOR DEPARTMENT USE						
18. _____	$	$	$	$	$	$
SECTION G – TOTAL						
19. TOTAL EXPENSES (Sum 5-17)	$	$	$	$	$	$
20. TOTAL HOURS (Sum 2,4)	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.

Medicaid Provider Number _____

SCHEDULE 25A – ALLOCATION OF DIETARY AND PLANT OPERATION AND MAINTENANCE EXPENSES

SECTION A – ALLOCAITON OF DIETARY EXPENSES

1. Total dietary expenses (from schedule 25, line 19) . . . . . $ _____
2. Deduct expense for food products provided to employes without charge (to line 9 below) . . . . . ($ _____)
3. Deduct amount for donated and surplus food commodities included in dietary expense (from schedule 16, line 1) . . . . . ($ _____)
4. Deduct revenue (related expense) for food products sold (from schedule 16, line 2) . . . . . ($ _____)
5. NET DIETARY EXPENSES TO ALLOCATE (to line 8 A below) . . . . . $ _____

	A. Total	B. Residents' Meals	C. Employes' Meals	D. Meals on Wheels	E. Other	F. Other
6. Meals served						
7. Ratio to total meals served to 4 decimals	1.0000					
8. DIETARY EXPENSE ALLOCATION . . . . (see instructions below line to complete)	$ From line 5	$ 8A X 7B	$ 8A X 7C	$ 8A X 7D	$ 8A X 7E	$ 8A X 7F

9. Food products provided to employes without charge (from line 2) . . . . . $ _____
10. Deduct revenue from meals sold to employees (from schedule 16, line 3) . . . . . (_____)
11. NET EXPENSE (PROFIT) FOR MEALS AND FOOD PROVIDED TO EMPLOYES

    (line 8C + line 9C – line 10C) . . . . . $ _____

SECTION B – ALLOCATION OF PLANT OPERATION AND MAINTENANCE EXPENSES

				Non-Nursing Home Areas w/ Plant Operation and Maint.		
	A. Total	B. Nursing Home Area	C. Emp. Unique Fringe Benefit Area	D.	E.	F.
12. Total square feet for areas						
13. Ratio to total square feet to 4 decimals . .	1.0000					
14. TOTAL PLANT OP/MAINT EXP. ALLOC.	$ From S25, L19	$ 14A X 13B	$ 14A X 13C	$ 14A X 13D	$ 14A X 13E	$ 14A X 13F

Medicaid Provider Number _____

SCHEDULE 25B – ALLOCATION OF HOUSEKEEPING, LAUNDRY, SECURITY AND TRANSPORTATION

SECTION A – ALLOCATION OF HOUSEKEEPING EXPENSES

	A. Total	B. Nursing Home Area	Non-Nursing Home Areas Receiving Housekeeping Services C.	D.	E.
15. Square feet or hours of service provided					
16. Ratio to total sq. ft./ hours to 4 decimals	1.0000				
17. TOTAL HOUSEKEEPING EXP. ALLOC.	$ From S25, L19	$ 17A X 16B	$ 17A X 16C	$ 17A X 16D	$ 17A X 16E

SECTION B – ALLOCATION OF LAUNDRY AND LINEN EXPENSES

	A. Total	B. Nursing Home Area	Non-Nursing Home Areas Receiving Laundry/Linen Services C.	D.	E.
18. Pounds of laundry processed					
19. Ratio to total pounds to 4 decimals	1.0000				
20. TOTAL LAUNDRY/LINEN EXP. ALLOC.	$ From S25, L19	$ 20A X 19B	$ 20A X 19C	$ 20A X 19D	$ 20A X 19E

SECTION C – ALLOCATION OF SECURITY EXPENSES

	A. Total	B. Nursing Home Area	Non-Nursing Home Areas Receiving Security Services C.	D.	E.
21. Total square feet of area					
22. Ratio to total square feet to 4 decimals . .	1.0000				
23. TOTAL SECURITY EXPENSE ALLOC.	$ From S25, L19	$ 23A X 22B	$ 23A X 22C	$ 23A X 22D	$ 23A X 22E

SECTION D – ALLOCATION OF TRANSPORTATION EXPENSES

	A. Total	B. Nursing Home Area	Non-Nursing Home Areas Receiving Transportation Services C.	D.	E.
24. Alloc. basis, Specify: _____					
25. Ratio to total alloc. basis to 4 decimals	1.0000				
26. TOTAL TRANS. EXPENSE ALLOC.	$ From S25, L19	$ 26A X 25B	$ 26A X 25C	$ 26A X 25D	$ 26A X 25E

Medicaid Provider Number _____

SCHEDULE 26 – ADMINISTRATIVE SERVICE EXPENSES

INSTRUCTIONS: For facilities managed by an outside, contracted management firm, the amount of management fee expense for the cost reporting period must be separately identified and reported on line 10 of this schedule. Enclose a copy of the management contract that was in effect during the cost reporting period.

SECTION A – SALARIES AND WAGES	**A.General Admin. Serv.**	**B. Medical Records**	**C. Central Supply**	**D.Accounting/Other Serv.**	**E. TOTAL (sum A-D)**
1. Expense for productive hours worked . . .	$	$	$	$	$
2. Number of productive hours worked	hrs.	hrs.	hrs.	hrs.	hrs.
3. Expense for non-productive hours	$	$	$	$	$
4. Number of non-productive hours	hrs.	hrs.	hrs.	hrs.	hrs.
5. TOTAL SALARY AND WAGE EXPENSE	$	$	$	$	$

SECTION B – RELATED ORGANIZATION CENTRAL SERVICE COSTS

6. Home office costs allocated to facility (from schedule 26A) . . . . . $ _____

7. County costs allocated to facility (from schedule 26A) . . . . . _____

SECTION C – NON-SALARY EXPENSES

8. Purchased services - legal . . . . . $ _____

9. Licensed bed assessment . . . . . _____

10. Contractual management fees . . . . . _____

11. Total other non-salary (from schedule 26 attachment) . . . . . _____

SECTION D – TOTAL

12. TOTAL ADMINISTRATIVE SERVICE EXPENSES (Sum 5 -11) . . . . . $ _____

Medicaid Provider Number _____

SCHEDULE 26 ATTACHMENT – OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES

INSTRUCTIONS: Itemize the expenses for other non-salary administrative service expenses which are reported on schedule 26, line 11. Use account descriptions from the facility general ledger with as much detail as possible.

	Description of Other Non-Salary Administrative Service Expenses	**Expense Amount**
1.		$
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.	TOTAL OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES (should equal schedule 26, line 11)	$

Medicaid Provider Number _____

SCHEDULE 26A – HOME OFFICE AND COUNTY CENTRAL SERVICE EXPENSES

INSTRUCTIONS: This schedule should be completed by any facility which is related by common ownership or control to a parent organization which provides centralized services to the nursing home or any county-operated nursing home which receives administrative services from centralized county services. Expenses which are indirectly allocated to this facility for home office or county centralized administrative services should be reported on schedule 26. The allocated costs must be reported from the organization's fiscal year which ended during the nursing home's cost report period.

SECTION A – GENERAL INFORMATION

1. Name and address of home office or county courthouse _____
2. Name and telephone number of contact at home office _____

SECTION B – HOME OFFICE COST ALLOCATION REPORT

Parent or chain organizations must submit a Home Office Cost Allocation Report or a Medicare Home Office Cost Statement (or other home office report form acceptable to Medicare). A copy of the completed report should be sent to DHFS at the Bureau of Fee-for-Service Health Care Benefits, DHCF, P.O. Box 309, Madison, WI 53701-0309.

A county facility can base the county centralized service costs allocated to the facility on the countywide cost allocation plan prepared in accordance with the policies and procedures contained in OMB Circular A-87, a separate Home Office Cost Allocation Report does not need to be completed.

SECTION C – AFFILIATED NURSING HOMES

Wisconsin Nursing Homes Operated by the Parent Organization or County (add additional sheets if necessary)	**City**
1.	
2.	
3.	
4.	

SECTION D – COSTS ALLOCATED TO THIS FACILITY

1. Amount of home office or county centralized costs allocated to this facility	$
2. Deduct the amount of return on owner's equity included in the line 1 amount	( )
3. Deduct expenses included in line 1 which are directly ascribable to this facility. Reclassify these expenses to their appropriate cost center and specify:	( )
_____	( )
_____	( )
_____	( )
4. NET HOME OFFICE OR COUNTY COSTS ALLOCATED TO THIS FACILITY (to schedule 26, line 6 or 7)	$

5. Amount on line 4 is from (date) _____ through (date) _____
6. Amount on line 4 is from (check one) ☐ Home Office Cost Allocation Report ☐ Medicare Home Office Cost Statement ☐ Countywide Cost Allocation Plan

7. Amount of salaries and wages included in line 4	$
8. Amount of fringe benefits included in line 4	$

Medicaid Provider Number _____

SCHEDULE 26B – ALLOCATION OF ADMINISTRATIVE SERVICE EXPENSES

INSTRUCTIONS: On line 17, enter the quantitative amounts for the allocation basis used by the facility. Describe the type of basis used and how it was determined.

1. Total Admin. Service Expense (S26, L12) **$** _____

SECTION A – DIRECT EXPENSES			**Non-Nursing Home Activities Receiving Administrative Services**		
Exp. Directly Ascribable To Each Activity	**A. Total**	**B. NH Provider**	**C.**	**D.**	**E.**
2.	$ ( )	$	$	$	$
3.	( )				
4.	( )				
5.	( )				
6.	( )				
7.	( )				
8.	( )				
9.	( )				
10.	( )				
11.	( )				
12.	( )				
13.	( )				
14.	( )				
15. TOTAL DIRECT EXP. (sum 2-14)	$ ( )	$	$	$	$
16. NET UNASSIGNED EXP. (line 1-line 15)	$				

SECTION B – ALLOC. OF INDIRECT EXP.	**A. Total**	**B. NH Provider**	**C.**	**D.**	**E.**
17. Allocation basis amounts					
18. Ratio to total basis to 4 decimals	1.0000				
19. UNASSIGNED ADMIN. EXP. ALLOC . . .	$ net from line 16	$ 19A X 18B	$ 19A X 18C	$ 19A X 18D	$ 19A X 18E
20. TOTAL ADMINISTRATIVE EXPENSE . .	$ (line 15A + 19A)	$ B15 + B19	$ C15 + C19	$ D15 + D19	$ E15 + E19

Medicaid Provider Number _____

SCHEDULE 27 – OTHER COST CENTERS

SECTION A – SALARIES AND WAGES	**A. Nurse Aide Training**	**B. Beauty/Barber Shop**	**C.**	**D.**	**E.**
1. Expense for productive hours worked . . .	$	$	$	$	$
2. Number of productive hours worked	hrs.	hrs.	hrs.	hrs.	hrs.
3. Expense for non-productive hours	$	$	$	$	$
4. Number of non-productive hours	hrs.	hrs.	hrs.	hrs.	hrs.
5. TOTAL SALARY AND WAGE EXPENSE	$	$	$	$	$

SECTION B – NON-SALARY EXPENSES	**A. Nurse Aide Training**	**B. Beauty/Barber Shop**	**C.**	**D.**	**E.**
6.	$	$	$	$	$
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					

SECTION C - TOTAL	**A. Nurse Aide Training**	**B. Beauty/Barber Shop**	**C.**	**D.**	**E.**
18. TOTAL EXPENSES (sum 5-18)	$	$	$	$	$

Medicaid Provider Number _____

SCHEDULE 28 – EMPLOYE FRINGE BENEFIT EXPENSES

SECTION A – FRINGE BENEFITS PAID ON BEHALF OF EMPLOYES

INSTRUCTIONS: under the column labeled "Self-Funded", indicate yes or no. If yes, attach documentation to support the amount claimed for each self-funded benefit.

Fringe Benefits Paid on Behalf of Employes	Self-Funded?	Expense
1. Employer's share of F.I.C.A.	☐ Yes ☐ No	$
2. State unemployment compensation	☐ Yes ☐ No	
3. Federal unemployment compensation	☐ Yes ☐ No	
4. Worker's compensation insurance	☐ Yes ☐ No	
5. Health insurance	☐ Yes ☐ No	
6. Life and disability insurance	☐ Yes ☐ No	
7. Wage continuation insurance	☐ Yes ☐ No	
8. Pension and deferred comp. plans (section C)	☐ Yes ☐ No	
9. Employee physicals	☐ Yes ☐ No	
10. Uniforms	☐ Yes ☐ No	$
11.	☐ Yes ☐ No	
12.	☐ Yes ☐ No	
13.	☐ Yes ☐ No	
14.	☐ Yes ☐ No	
15. TOTAL PAID ON BEHALF OF EMPLOYES (sum 1-14)		
16. Expense for special salary or wage payments to employes not included elsewhere (section D)		
17. TOTAL FRINGE BENEFIT EXPENSE (sum 15+16)		$

SECTION B – SELF-EMPLOYMENT TAXES

INSTRUCTIONS: If a nursing home is a sole proprietorship or partnership, complete the following for self-employment taxes as reported for the year ending during the cost reporting period. Do not include self-employment taxes in line 1.

Owner's Name	Salary or Net Income	Self-Emp. Tax Paid	Owner's Name	Salary or Net Income	Self-Emp. Tax Paid
	$	$		$	$
	$	$		$	$

SECTION C – PENSION AND DEFERRED COMPENSATION PLANS

INSTRUCTIONS: For the purpose of benefits, some pension plans recognize years of service built up by employes before the plan was established. Briefly explain how the pension expense for service from prior years is amortized to or recognized in this cost reporting period. List the amount of expense for prior year service included in line 8.

SECTION D – SPECIAL SALARY AND WAGE PAYMENTS TO EMPLOYES

INSTRUCTIONS: Check the types of special salary and wage payments to employes which are included in section A, line 16.

☐ Christmas bonus ☐ Longevity bonus ☐ Productivity bonus ☐ Other, Specify: _____

☐ Bonuses to owners and immediate family relations, Specify: _____

Medicaid Provider Number _____

SCHEDULE 29 – HEATING FUEL AND UTILITY EXPENSES

INSTRUCTIONS: Report the accrued expense incurred during the cost reporting period for each type of heating fuel and utility service.

Accounts payable: The expense should be adjusted to excluded beginning accounts payable and to include ending accounts payable for the reporting period. Make sure to include exactly 12 months of expense for a full-year cost report and exactly six months of expense for a six-month cost report.

Inventories: The expense for heating fuels such as heating oil, L.P. gas and coal should be adjusted for changes in inventories between the beginning and ending dates of the cost reporting period.

Cost allocation: In section B, allocate the fuel and utility expense between the Medicaid nursing home area and other major revenue-generating areas or non-nursing home areas. Describe the allocation technique if an allocation basis other than square footage is used. The allocation basis used is similar to the maintenance allocation on schedule 25A.

SECTION A – ACCRUED EXPENSE BY TYPE	Accrued Expense	Expense by Type	Accrued Expense
1. Fuel oil	$	6. Water and sewer utility charges	$
2. Natural gas		7. Purchased steam	
3. L.P. gas		8.	
4. Coal		9.	
5. Electricity		10. TOTAL FUEL AND UTILITY EXPENSE	$

SECTION B – ALLOCATION OF FUEL AND UTILITY EXPENSE

	A. Total	B. NH Area	C. Emp. Unique Fringe Ben. Area	Non-NH Areas, Other Rev. Areas Receiving Fuel/Util. Serv. D.	E.	F.
11. Total square feet for areas						
12. Ratio to total square feet to 4 decimals	1.0000					
13. TOTAL ALLOC. FUEL/UTIL. EXPENSE	$	$	$	$	$	$
	From line 10	13A X 12B	13A X 12C	13A X 12D	13A X 12E	13A X 12F

Medicaid Provider Number _____

SCHEDULE 30 – INTEREST EXPENSES ON OPERATING WORKING CAPITAL LOANS

Name of Lender	Is Lender a Related Party?	Interest Expense
1a. _____	b. ☐ Yes ☐ No	$
2a. _____	b. ☐ Yes ☐ No	
3a. _____	b. ☐ Yes ☐ No	
4a. _____	b. ☐ Yes ☐ No	
5a. _____	b. ☐ Yes ☐ No	
6. TOTAL EXPENSES ON OPERATING WORKING CAPITAL LOANS (sum 1-5)		$

SCHEDULE 31 – INSURANCE EXPENSES

Type of Insurance Coverage	Self-funded?	Insurance Expense
1. Property insurance on building and contents	☐ Yes ☐ No	$
2. Automobile insurance	☐ Yes ☐ No	
3. Liability insurance	☐ Yes ☐ No	
4. Business interruption insurance	☐ Yes ☐ No	
5. Life insurance on owners and employes with facility as the beneficiary	☐ Yes ☐ No	
6. Mortgage insurance	☐ Yes ☐ No	
7. _____	☐ Yes ☐ No	
8. _____	☐ Yes ☐ No	
9. TOTAL INSURANCE EXPENSE		$

SCHEDULE 32 – AMORTIZATION OF DEFERRED EXPENSES

A. Deferred Exp. or Asset Being Amortized (give detailed description)	B. Original Cost	C. Year Cost Incurred	D. Number of Years Amortized	E. Unamortized Begin. Balance	F. Unamortized End. Balance	G. Amortization Expense
1. _____	$			$	$	$
2. _____						
3. _____						
4. _____						
5. TOTAL AMORTIZATION EXPENSE						$

Medicaid Provider Number _____

SCHEDULE 33 – INTEREST EXPENSES ON PLANT ASSET LOANS

Lender Name and Purpose of Loan	A. Original Month, Year of Loan	B. Maturing Month,Year of Loan	C. Original Amount of Loan	Remaining Balance of Loan Principal D. Begin date / Begin Bal.	E. 6Mo.date / 6 Mo. Bal.	F. End date / End Bal.	G. Interest Rate	H. Interest Expense
1a.Name _____								
1b. Related party? ☐ Yes ☐ No			$	$	$	$	%	$
1c.Purpose _____								
2a.Name _____								
2b. Related party? ☐ Yes ☐ No			$	$	$	$	%	$
2c.Purpose _____								
3a.Name _____								
3b. Related party? ☐ Yes ☐ No			$	$	$	$	%	$
3c.Purpose _____								
4a.Name _____								
4b. Related party? ☐ Yes ☐ No			$	$	$	$	%	$
4c.Purpose _____								
5a.Name _____								
5b. Related party? ☐ Yes ☐ No			$	$	$	$	%	$
5c.Purpose _____								
6a.Name _____								
6b. Related party? ☐ Yes ☐ No			$	$	$	$	%	$
6c.Purpose _____								
7a.Name _____								
7b. Related party? ☐ Yes ☐ No			$	$	$	$	%	$
7c.Purpose _____								
8. TOTAL LOAN PRINCIPAL				$	$	$	TOTAL EXP.	$

Medicaid Provider Number _____

SCHEDULE 34 – DEPRECIATION EXPENSES

SECTION A – CAPITALIZED HISTORICAL COST

	Begin Date _____ B. Beginning Balance	C. Additions During Report Period	D. Disposals During Report Period	End Date _____ E. Ending Balance
1. Land	$	$	$ ( )	$
2. Land improvements			( )	
3. Buildings			( )	
4. Leasehold improvements			( )	
5. Fixed equipment			( )	
6. Moveable equipment			( )	
7. Transportation vehicles			( )	
8. _____			( )	
9. _____			( )	
10. TOTAL CAPITALIZED COST	$	$	$ ( )	$

SECTION B – DEPRECIATION EXPENSE AND ACCUMULATION DEPRECIATION

	A. Depreciation Method, Lives Used	Begin Date _____ B. Beginning Balance	C. Depreciation Exp. During Report Period	D. Removal of Accum. Deprec. on Disposals.	End Date _____ E. Ending Balance
11. Land improvements		$	$	$ ( )	$
12. Buildings				( )	
13. Leasehold improvements				( )	
14. Fixed equipment				( )	
15. Moveable equipment				( )	
16. Transportation vehicles				( )	
17. _____				( )	
18. _____				( )	
19. TOTAL ACCUMULATED DEPRECIATION		$		$ ( )	$
20. TOTAL DEPRECIATION EXPENSE			$		

Medicaid Provider Number _____

SCHEDULE 35 – LEASE EXPENSES ON OPERATING LEASES AND NON-CAPITALIZED LEASES

INSTRUCTIONS: For any lessor that is a related party to the provider, report the lessor's ownership cost of the property and complete and attach copies of schedules 31, 32, 33, 34, 37 and 39. Label the schedule copies, "Related Party Leased Property".

For any lease contract expense which totals above $5,000, submit a copy of the lease.

Identify any of the leased property listed below which was formerly owned by the leasing provider.

SECTION A – LEASE EXPENSE FOR LAND, BUILDING AND FIXED EQUIPMENT

	A. Name of Lessor	B. Related Party?	C. Lease Purchase Agreement?	D. Lessor Acquisition Cost (if known)	E. Month, Year acquired use	F. Describe Property	G. Lease Exp.
1.		☐ Yes ☐ No	☐ Yes ☐ No	$			$
2.		☐ Yes ☐ No	☐ Yes ☐ No	$			
3.		☐ Yes ☐ No	☐ Yes ☐ No	$			

SECTION B – LEASE EXPENSE FOR MOVEABLE EQUIPMENT AND OTHER LEASES

	A. Name of Lessor	B. Related Party?	C. Lease Purchase Agreement?	D. Lessor Acquisition Cost (if known)	E. Month, Year acquired use	F. Describe Property	G. Lease Exp.
4.		☐ Yes ☐ No	☐ Yes ☐ No	$			$
5.		☐ Yes ☐ No	☐ Yes ☐ No	$			
6.		☐ Yes ☐ No	☐ Yes ☐ No	$			
7.		☐ Yes ☐ No	☐ Yes ☐ No	$			
8.		☐ Yes ☐ No	☐ Yes ☐ No	$			

SECTION C – TOTAL

9. TOTAL LEASE EXPENSE ON OPERATING LEASES AND NON-CAPITALIZED LEASES (sum 1-8) . . . . . $ _____

Medicaid Provider Number _____

SCHEDULE 36 – LEASE EXPENSES ON CAPITALIZED LEASES

INSTRUCTIONS: For any lessor that is a related party to the provider, report the lessor's ownership cost of the property and complete and attach copies of schedules 31, 32, 33, 34, 37 and 39. Label the schedule copies "Related Party Leased Property".

For any lease contract expense which totals above $5,000, submit a copy of the lease.

Identify any of the leased property listed below which was formerly owned by the leasing provider.

SECTION A – CAPITALIZED LEASE INFORMATION

Lease Expense

1. Name of lessor . . . . . _____
   Is lessor a related party? . . . . . ☐ Yes ☐ No
   Date use of property was acquired . _____
   Ensuring date of lease . . . . . _____
   Is this a lease purchase agreement? ☐ Yes ☐ No
   Description of leased property . . . . . _____

   1a. Amortization of capitalized lease value . . . . . $ _____
   1b. Interest expense on capital lease obligation . . . . . _____
   1c. Accrued contingent lease payments for period . . . . . _____
   1d. SUBTOTAL LEASE EXPENSE (sum 1a-1c) . . . . . $ _____

2. Name of lessor . . . . . _____
   Is lessor a related party? . . . . . ☐ Yes ☐ No
   Date use of property was acquired . _____
   Ensuring date of lease . . . . . _____
   Is this a lease purchase agreement? ☐ Yes ☐ No
   Description of leased property . . . . . _____

   2a. Amortization of capitalized lease value . . . . . $ _____
   2b. Interest expense on capital lease obligation . . . . . $ _____
   2c. Accrued contingent lease payments for period . . . . . $ _____
   2d. SUBTOTAL LEASE EXPENSE (sum 2a-2c) . . . . . $ _____

3. TOTAL CAPITALIZED LEASE EXPENSE FOR REPORTING PERIOD – transfer to schedule 12 (sum 1d+2d) . . . . . $ _____

SECTION B – ACTUAL LEASE PAYMENTS RELATED TO CAPITALIZED LEASES

A1. Name of lessor . . . . . _____
A2. Actual payments required by lease in report period . . . $ _____
A3. Are any capitalized costs reported on other schedules? . . . . . ☐ Yes ☐ No
A4. If yes, (schedule) _____ (line) _____ (amount) $ _____

B1. Name of lessor . . . . . _____
B2. Actual payments required by lease in report period . . . $ _____
B3. Are any capitalized costs reported on other schedules? . . . . . ☐ Yes ☐ No
B4. If yes, (schedule) _____ (line) _____ (amount) $ _____

Medicaid Provider Number _____

SCHEDULE 37 – PROPERTY TAX EXPENSES

INSTRUCTIONS: Only tax exempt facilities should report the expense for municipal services which are financed through municipality property taxes. Describe the services.

SECTION A – REAL ESTATE, PERSONAL PROPERTY, AND MUNICIPAL SERVICE EXPENSES — **Expense**

1. Real estate tax . . . . . **$** _____

2. Personal property tax . . . . . _____

3. _____ $ _____

4. _____ _____

5. _____ _____

6. _____ _____

7. TOTAL MUNICIPAL SERVICE EXPENSES (sum 3-6) . . . . . $ _____

8. TOTAL PROPERTY TAX AND/OR MUNICIPAL SERVICE EXPENSE (sum 1,2,7) . . . . . $ _____

SECTION B – FOR ALL PROVIDERS — **Expense**

1. 2004 real estate tax (due in 2005) relating to the nursing home operation (attach copy of bill or, if not yet received, send separately upon receipt.) $ _____

2. 2004 personal property tax (due in 2005) relating to the nursing home operation (attach copy bill or, if not yet received, send separately upon receipt.) _____

3a. Have the amounts reported on lines 1 and 2 been paid in full? • Yes, go to question 3b • No, explain below

Date(s) paid _____ Amount(s) paid _____ Amount still outstanding _____

3b. Are there any real estate or personal property tax still outstanding from prior years, eg. 2002 or 2003? • Yes, explain below • No

Tax year _____ Amount still outstanding _____ Tax year _____ Amount still outstanding _____

SECTION C – FOR TAX-EXEMPT PROVIDERS ONLY — **Expense**

4. Amount of municipal service fee expense incurred by the nursing home appropriately accrued to calendar year 2004. $

5. Identify where municipal service fee expenses are reported in the cost report if not above on this schedule, section A, line 7.

Cost center name _____ Schedule number _____ Line number _____ Amount reported $ _____

6. The facility began to pay municipal service fees (check one) • Prior to January 2004 • In or after January 2004 Date began paying fees _____

7. Describe the services provided by the municipality for the above fees. _____

8. Payment of the above fees was (check one) • Voluntary • Required by the tax authority

Medicaid Provider Number _____

SCHEDULE 38 – INCOME TAX EXPENSES

INSTRUCTIONS: Completion of this schedule is optional. Report estimated income tax.

Type of Tax	Tax Expense
1. State income tax	**$**
2. Federal income tax	
3.	
4.	
5.	
6. TOTAL ESTIMATED INCOME TAX EXPENSES (sum 1-5)	$

SCHEDULE 39 – OTHER NON-SALARY EXPENSES

INSTRUCTIONS: Report and describe the nature and source of any non-salary expenses not included elsewhere in this cost report. Other salary expenses should be reported on schedule 27.

Nature and Source of Expense	Expense
1.	$
2.	
3.	
4. TOTAL OTHER NON-SALARY EXPENSES (sum 1-3)	$

Medicaid Provider Number _____

SCHEDULE 40 – ALLOCATION OF PROPERTY EXPENSES

INSTRUCTIONS: Assign expenses directly ascribable to or identifiable with each service's building area. Use column C for unique fringe benefit building areas.

			Areas for Non-NH Serv. or Other Major Revenue-Generating Activities		
SECTION A – DIRECT PROPERTY EXP.	**A. Total From Sched.**	**B. NH Service Area**	**C.**	**D.**	**E.**
1. Property insurance (s31)	$	$	$	$	$
2. Mortgage insurance (s31)					
3. Amortization debt premium discount (s32)					
4. Plant asset interest expense (s33)					
5. Depreciation land improvements (s34)					
6. Depreciation buildings (s34)					
7. Depreciation leasehold improve. (s34)					
8. Depreciation fixed equipment (s34)					
9. Depreciation moveable equip. (s34)					
10. Depreciation transportation veh. (s34)					
11. Depreciation other (s34)					
12. Expense on operating leases (s35)					
13. Expense on capitalized leases (s36)					
14. Property taxes or fees (s37)					
15. TOTAL EXPENSE (sum 1-14)	$	$	$	$	$
16. Less total directly assigned property exp.	$	(sum 15B, 15C, 15D, 15E)			
17. NET UNASSIGNED/INDIRECT PROP.	$	(15A less 16A)			

SECTION B – NON-SALARY EXPENSES	**A. Total**	**B. NH Area**	**C.**	**D.**	**E.**
18. Square feet of service's building area					
19. Ratio to total square feet to 4 decimals	1.0000				
20. Indirect property expense allocation	$ (from 17A)	$ 20A X 19B	$ 20A X 19C	$ 20A X 19D	$ 20A X 19E

SECTION C – TOTAL	**A. Total**	**B. NH Area**	**C.**	**D.**	**E.**
21. TOTAL PROP. EXP. FOR EACH AREA .	$ 17A + 20 A	$ 15B + 20B	$ 15C + 20C	$ 15D + 20D	$ 15E + 20E

Medicaid Provider Number _____

SCHEDULE 41 – ACCOUNTING AND REPORTING POLICIES

SECTION A – POLICIES AND PRACTICES

1. Accounting method – expenses are to be reported on the accrual method of accounting except for governmental facilities, which may use the cash method. Check the accounting method used in this cost report . . . . . ☐ Accrual ☐ Cash

2. Capitalization of plan assets – briefly describe the facility's policy or practice for the capitalization of plant asset purchases.

_____

_____

_____

3. Volunteer and unpaid employes – briefly explain if and how volunteer and other unpaid employe hours are reported in this cost report

_____

_____

_____

4. Conformity – describe any accounting practices/policies in reporting revenues and expenses which are known to NOT conform to generally accepted accounting principles.

_____

_____

_____

SECTION B – NON-PRODUCTIVE SALARY EXPENSE AND HOURS

INSTRUCTIONS: Reporting on the basis of earned time-off is not permitted. Non-productive salaries and hours must be reported on the basis of the time-off which was actually taken by employes during the cost reporting period. For column C, describe the estimation techniques used and add sheets if needed.

Type of Paid Time-Off	A. Reported in Non-Productive Expense and Hours?		B. Based on Actual or Earned Time-Off?		C. Are Reported Amounts an Estimate?	
1. Vacation	☐ Yes	☐ No	☐ Actual	☐ Earned	☐ Yes	☐ No
2. Holidays	☐ Yes	☐ No	☐ Actual	☐ Earned	☐ Yes	☐ No
3. Sick time	☐ Yes	☐ No	☐ Actual	☐ Earned	☐ Yes	☐ No
4. Break, meal time	☐ Yes	☐ No	☐ Actual	☐ Earned	☐ Yes	☐ No
5. Holiday premium	☐ Yes	☐ No	☐ Actual	☐ Earned	☐ Yes	☐ No
6. In-service training	☐ Yes	☐ No	☐ Actual	☐ Earned	☐ Yes	☐ No
7. _____	☐ Yes	☐ No	☐ Actual	☐ Earned	☐ Yes	☐ No

Medicaid Provider Number _____

SCHEDULE 42 – IDENTIFICATION OF EXPENSES FROM TRANSACTIONS WITH RELATED PARTIES AND ORGANIZATIONS

SECTION A – RELATED PARTY LEASES

A. Description of Expense Item	Location and Amount of Expense Included In This Cost Report					G. Expense Incurred by Related Party	H. Difference (G – F)
	B. Cost Ctr.	C. Schedule	D. Column	E. Line	F. Expense		
1. Total related party lease expense					$ ( )	XXXXXXXXX	XXXXXXXXXX
2. Insurance expense					XXXXXXXXX		XXXXXXXXXX
3. Amortized deferred expense					XXXXXXXXX		XXXXXXXXXX
4. Interest expense					XXXXXXXXX		XXXXXXXXXX
5. Depreciation expense					XXXXXXXXX		XXXXXXXXXX
6. Property tax expense					XXXXXXXXX		XXXXXXXXXX
7. _____					XXXXXXXXX		XXXXXXXXXX
8. _____					XXXXXXXXX		XXXXXXXXXX
9. SUBTOTAL FOR RELATED PARTY LEASES					$ ( )	$	$

SECTION B – OTHER RELATED PARTY TRANSACTIONS

10. _____					$ ( )	$	$
11. _____							
12. _____							
13. _____							
14. _____							
15. TOTAL AMOUNT TO ADJUST RELATED PARTY TRANSACTIONS TO COST (to schedule 11, line 18)							$

SECTION C – IDENTIFICATION OF RELATED PARTIES

16. List the names and cities of location of the related parties and organizations with whom the nursing home provider has transacted business during the cost reporting period.

_____

_____

_____

Medicaid Provider Number _____

SCHEDULE 43 – IDENTIFICATION OF EXPENSES NOT RELATED TO PATIENT CARE

INSTRUCTIONS: To the extent possible, identify significant expenses included in this cost report which were not related to patient care. See Section 600 of the Instruction Booklet for more details on such expenses and attach additional sheets if necessary.

		Location of Expense In Cost Report			
Expense Item	**Amount**	**Cost Ctr.**	**Schedule**	**Column**	**Line**
1. Promotional expenses	$				
2. Gifts and flowers					
3. Personal expenses of owners					
4. Entertainment for non-residents					
5. Telephone, television, and radio in resident rooms					
6. Contributions and donations					
7. Fines and penalties					
8. Interest expense on non-care working capital loans					
9. Interest expense on non-care plant asset loans					
10. Non-care related membership fees					
11. Training programs for non-employes					
12. Special legal and professional fees (complete schedule 43A)					
13. Owner or key person life insurance					
14. Taxes					
15. Fund raising expenses					
16. Excess property					
17. _____					
18. _____					
19. _____					

Medicaid Provider Number _____

SCHEDULE 43A – LEGAL FEES

INSTRUCTIONS: Identify the expenses for all legal fees included in this cost report. These expenses should have been reported on schedule 26, line 8. For the fees reported on line 2, identify any allowable amount that was specifically awarded by the administrative or judicial courts as a result of a successful appeal or prosecution.

Description	Legal fees
1. Prosecution or defense related to Medicare or Medicaid reimbursement	$
2. Prosecution or defense pertaining to compliance with licensure or certification requirements (see instructions above)	
3. Defense of an owner or employe in a personal or criminal legal matter	
4. Legal preparation resulting in the filing of an appeal under Chapters 50 or 227, Wisconsin Statutes, or a judicial suit	
5. Collection of delinquent accounts	
6. Corporate restructuring or reorganization	
7. Potential purchase or sale of nursing home(s)	
8. Purchase or sale of nursing home(s)	
9. Negotiations with suppliers	
10. Income taxes, payroll taxes, benefit plans	
11. Union related activities	
12. Guardianship for Medicaid residents	
13. Other not related to patient care	
14. _____	
15. _____	
16. TOTAL LEGAL FEES (should equal schedule 26, line 8)	$

Medicaid Provider Number _____

SCHEDULE 44 – IDENTIFICATION OF COMPENSATION TO KEY PERSONNEL

INSTRUCTIONS: Report the compensation paid to all owners and other related parties and immediate family relationships, all workers who are members of a religious order or society that owns the nursing home, and arm's length employes who are supervisors and managers with decision making authority. See reference charts below for columns B and D.

A. Name	B. Title (see list below)	C. Sex	D. Level of Education	E. Years of Experience	F. Total Comp. Expense This Facility	G. Hours per Year This Facility	H. Hrs. per Yr. Other Health Care Provider	I. Member of Religious Order?	J. Owner or Family Relation?
1.		☐ Male ☐ Fem.			$			☐ Yes ☐ No	☐ Yes ☐ No
2.		☐ Male ☐ Fem.						☐ Yes ☐ No	☐ Yes ☐ No
3.		☐ Male ☐ Fem.						☐ Yes ☐ No	☐ Yes ☐ No
4.		☐ Male ☐ Fem.						☐ Yes ☐ No	☐ Yes ☐ No
5.		☐ Male ☐ Fem.						☐ Yes ☐ No	☐ Yes ☐ No
6.		☐ Male ☐ Fem.						☐ Yes ☐ No	☐ Yes ☐ No
7.		☐ Male ☐ Fem.						☐ Yes ☐ No	☐ Yes ☐ No
8.		☐ Male ☐ Fem.						☐ Yes ☐ No	☐ Yes ☐ No
9.		☐ Male ☐ Fem.						☐ Yes ☐ No	☐ Yes ☐ No

10. TOTAL COMPENSATION FOR THIS FACILITY . . . . . $ _____

TITLE / RESPONSIBILITY AREA (Column B)

ADM	Administrator
ASST ADM	Assistant Administrator
OTH ADM	Other Administrator, Specify.
CFO	Chief Financial Officer
BUS MGR	Business Manager
PERSON	Personnel Manager
DON	Director of Nursing
NURSE	Nursing Supervisor
DIET	Dietary Supervisor
MAINT	Maintenance Supervisor
HSK	Housekeeping Supervisor
LAUND	Laundry Supervisor
OTHER	Other, Specify.

LEVEL OF EDUCATION (Column D)

HS	High School Diploma
NS	Nursing School Diploma, Associate Degree
BS	Baccalaureate Degree (BS, BA, BSN)
MS	Master's Degree (MS, MA, MSN)
PHD	Doctorate Degree

Medicaid Provider Number _____

SCHEDULE 45 – DISTRIBUTION OF COMPENSATION EXPENSES TO KEY PERSONNEL

INSTRUCTIONS: For each person listed on schedule 44, separately itemize and identify the amount of compensation expense and hours reported in each cost center of this cost report. Total compensation reported on this schedule should agree with the total reported on schedule 44, column F.

		Location of Expense in Cost Report			Productive Hours		Non-Productive Hrs.		Purchased Serv.	
	A. Name	B. Cost Ctr.	C. Schedule	D. Column	E. Expense	F. Hrs	G. Expense	H. Hrs	I.Expense	J. Hrs
1.					$		$		$	
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
11.										
12.										
13. TOTAL EXPENSE (for columns E, G, and I only)					$		$		$	

Medicaid Provider Number _____

SCHEDULE 46 – IDENTIFICATION OF EXPENSES FOR EMPLOYEE UNIQUE FRINGE BENEFITS

INSTRUCTIONS: Unique fringe benefits are those fringe benefit items provided to only a few select employes and the expenses for such benefits may be reported in one or more cost centers of this report. Identify the unique fringe benefits provided to any individual employe by reporting the expenses related to the benefit and where the expenses are included in this cost report. If the expense for a benefit is less than $800 per year, it does not have to be reported on this schedule.

					Location and Amount of Benefit Expense in Cost Report			
A. Name of Employe	**B. Title**	**C. Describe Unique Fringe Benefit Item**	**D. Cost Ctr. Salary Exp.**	**E. Cost Ctr. Benefit Exp.**	**F. Schedule**	**G. Column**	**H. Line**	**I. Expense Amount**
1.								$
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								
16.								

Medicaid Provider Number _____

SCHEDULE 47 – ADMINISTRATIVE SERVICES PROVIDED TO OTHER NURSING HOMES AND ENTERPRISES

INSTRUCTIONS: On this schedule, report only the key administrative personnel identified on schedule 44 who also have responsibility for certain areas other than this nursing home. For supervisors or managers with decision making authority for another nursing home, a hospital, a community-based residential facility (CBRF), or an apartment complex, identify the employe(s) and the total number of beds/units in the appropriate column.

		Number of Beds in Each Facility		
Name	**Other Nursing Homes**	**Hospitals**	**CBRFs**	**Apartments**
1.				
2.				
3.				
4.				
5.				
6.				

SCHEDULE 48 – OUT-OF-STATE TRAVEL EXPENSES

INSTRUCTIONS: Report the amount of out-of-state travel expenses included in this cost report but do NOT include expenses for travel to and from the facility's home office, travel within 100 miles of the Wisconsin border, or travel for home office personnel when one or more associated nursing homes are located outside of Wisconsin. Types of travel expenses that should be included are meals, lodging, transportation, and training, seminar, and convention fees/expenses associated with out-of-state trips. Attach additional sheets if necessary.

Employe Name, Destination, Purpose of Trip	**Schedule**	**Line**	**Amount**
1.			$
2.			$
3.			$

Medicaid Provider Number _____

SCHEDULE 49 – PERCENTAGE OF OWNERSHIP

INSTRUCTIONS: List all individuals or entities that own 20% or more of the nursing home operation

	Name of Individual or Entity	Percentage of Ownership
1.		
2.		
3.		
4.		
5.		

SCHEDULE 50 – INTEREST IN OTHER MEDICAID PROVIDERS

INSTRUCTIONS: If the nursing home organization or any of its owners, administrators, officers, or any members of their immediate families are a separate provider or had an interest in any other provider in the Wisconsin Medicaid program, list the provider and explain the nature of the interest. Report interests that existed during the cost report period and/or existed up to the date of submission of the cost report to the Department. Include any other Wisconsin nursing home providers.

	Name and City of Medicaid Provider	Type of Medical Services Provided	Nature and Extent of Interest in Provider
1.			
2.			
3.			
4.			
5.			

Medicaid Provider Number _____

SCHEDULE 51 – MEDICAL SUPPLY REVENUES FROM MEDICARE PART B

INSTRUCTIONS: Wisconsin Medicaid policies and statutory authority on Medicare maximization include nursing homes billing Medicare for medical supplies and equipment under Medicare Part B. All Medicare-certified nursing homes should be billing Medicare Part B for services and supplies covered by the Medicare program. Nursing homes that are not Medicare certified may bill Medicare under Part B for medical supplies if they have separate Medicare certification as a durable medical equipment and supply vendor. Nursing home revenues from Medicare Part B should be included in the medical supply revenue on schedule 14 and must be identified on this schedule to property account for third party payer revenues.

1. Does the nursing home bill Medicare for covered medical supplies under Medicaid Part B for Medicare eligible residents? . . . . . ☐ Yes ☐ No

2. Is the nursing home Medicare certified? . . . . . ☐ Yes ☐ No
   If yes, submit a copy of worksheet D from the most recent Medicare Cost Report.

3. Does the nursing home have a separate Medicare certification to bill for equipment and supplies? . . . . . ☐ Yes ☐ No

4. Medical supplies are billed to Medicare for the following types of residents (check all that apply) . . . . . ☐ Private Pay ☐ Title XIX (Medicaid) ☐ Other

5. What were the Medicare Part B revenues for medical supplies? . . . . . $ _____

6. What were the costs related to the above medical supply revenues and where were they reported on this cost report?

   a. Expense $ _____ schedule _____ column _____ line _____

   b. Expense $ _____ schedule _____ column _____ line _____

Medicaid Provider Number _____

SCHEDULE 52 – MISCELLANEOUS MEDICAID NON-RATE REVENUES

INSTRUCTIONS: Wisconsin Medicaid provides for separate reimbursement for certain items not included in the daily rate or for additional reimbursement over and above the daily rate for certain services. For the items listed below, identify the revenue accrued by your facility for the services provided during the cost reporting period and where the revenues were reported in this cost report (should be included on schedules 14 through 18).

On lines 1 and 2, the amounts reported should only reflect the revenues in excess of the Medicaid daily rate for residents' levels of care and for which the related expenses are included in this cost report. For example, a resident at the ISN level of care is also authorized for a supplemental payment of $325 per day as an extensive care patient. The facility's ISN rate is $102 per day. The revenue reported on this schedule in excess of the of the level of care daily rate is $223 per day.

On line 5, report the amount of reimbursement from the Medicaid program for specialized services (active treatment) for mentally ill residents who were determined to be in need of such services by a level II pre-admission screening and annual resident review.

Medicaid Revenue Item	Revenue Amount	Location in Cost Report: Schedule	Location in Cost Report: Line
1. Extensive care patients excluding ventilator- dependent	$		
2. Residents with AIDS or AIDS-related complex			
3. Exceptional supply needs			
4. Personalized durable medical equipment including Clinitron beds and motorized wheelchairs			
5. Specialized services for the mentally ill			
6. Level 1 screening (number of screenings) _____ X (payment per screening) $ _____ =			
7a. Nurse aide training and competency evaluations – revenues from training aides for other facilities			
7b. Nurse aide training and competency evaluations – revenues from training aides for your own facility			
7c. Nurse aide training and competency evaluations – revenues for performing competency evaluations			
8. TOTAL MISCELLANEOUS MEDICAID NON-RATE REVENUES (sum 1-7)	$		

Medicaid Provider Number _____

SCHEDULE 53 – PRIVATE ROOM INCENTIVES

INSTRUCTIONS: Based on the information provided in the cost report, your facility may qualify for the Basic Private Room Incentive (BPRI) or Replacement Private Room Incentive (RPPRI) as explained in Section 2.720 of the Methods of Implementation. A facility may receive only one of the two private room incentives.

A facility will qualify for the BPRI if it has exceptional Medicaid/Medicare utilization and at least 15% of the total beds are licensed for single occupancy.

A facility will qualify for the RPPRI if it has exceptional Medicaid/Medicare utilization and is replacing 100% of patient rooms after July 1, 2000.

Indicate if your facility is requesting a private room incentive

☐ Yes, my facility is requesting a private room incentive. Specify one: ☐ BPRI ☐ RPPRI

☐ No, my facility is not requesting the BPRI or RPPRI.

If your facility is requesting one of the incentives, you must complete the affidavit below and return it to the Department by July 1, 2005, to qualify for one of the private room incentives.

AFFIDAVIT

I HEREBY ATTEST and affirm that from July 1, 2005 to June 30, 2006, the _____ nursing home will not charge Medicaid residents any amount for private rooms including but not limited to the surcharge as provided under Chapter HFS 107.09(4)(k), Wis. Admin. Rules. I furthermore acknowledge that all payments the facility has received for the Medicaid Basic Private Room Incentive (BPRI) or Replacement Private Room Incentive (RPPRI) may be recouped retroactive to July 1, 2005, if the facility has charged Medicaid residents for private rooms during this period.

SIGNATURE – Original Signature of Officer or Administrator of Nursing Home	Title	Date Signed

For Department Use	Date Received	Medicaid District Auditor